
# Health and Dental History

**(Please print, complete all questions, and bring with you to your appointment)**

Our office may be unlike any other dental office you have visited. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. These are issues you may have never thought about. Please check what best expresses how you feel about the following questions.

**Do you have any areas of concern?**

**What do you think the present state of the health of your mouth is?**

**Do you have any friends or family that already come to our office?**

**How did you hear about our office?**

**How healthy do you want us to get your mouth?**

○ Don't really care ○ Average ○ The best it can be

**Should you need treatment, at what point should we address it?**

○ When my tooth hurts or breaks ○ When something is worsening ○ When something isn't ideal

**What quality of dentistry do you want us to recommend?**

○ Just patch it ○ Average ○ Ideal/The Best

**We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you?**

○ As a restorative dentist ○ Average ○ Ideal/The Best

**Is there anything you would like to change about the appearance of your smile?**

**When was your last dental visit or appointment?**

**Tell us about your good dental experiences.**

**Any bad dental experiences?**

**What caused you to leave your last dental office?**

**Is there any additional information you would like us to know?**

## Employment Information

**Employer:**

**How long there:**

**Occupation:**

# Insurance Information

**Insurance Company Name:**

**Phone # :**

**Insured's Name:**

**Insured's SSN:**

**Plan ID Number:**

**Group Number:**

I understand that this office does accept insurance benefits for primary insurance only. We will gladly assist you to maximize your dental benefits, however we ask that you pay the estimated non-covered balance at the time of service. I also understand that my insurance policy is an agreement between the insurance company and myself, therefore I am ultimately responsible for all fees incurred for my dental treatment.

I understand that I must give 24 hours notice prior to canceling an appointment or an administrative fee may be charged to my account.

Our office accepts Visa, MasterCard, cash and personal check. We have also arranged for interest free financing, and payment plans for up to 60 months with Care Credit, Lending Club and Proceed Finance.

**Signature of Patient**

**Date**

# Health and Dental History

**(Please print, complete all questions, and bring with you to your appointment)**

**Patients Name:**

**I prefer to be called:**

**Street Address:**

**APT/Suite/Unit:**

**City:**

**State:**

**Zip:**

**Home phone:**

**Cell phone:**

**Work phone:**

**SSN:**

**Date of Birth:**

**E-Mail:**

**Physician's Name:**

**Phone number:**

**Are you taking any medication now, including regular dosages of aspirin?**

○ **Yes** ○ **No**

**If so, please list name and dosage**

**Are you aware of having an allergic reaction to any medication or substance?**

○ Yes ○ No

**If so, please list.**

**Have you been under the care of a medical doctor during the past two years?**

○ Yes ○ No

**If so, for what.**

**Have you seen an ENT (ear, nose, throat doctor)?**

○ Yes ○ No **Dr. Name:**

**Have you seen a chiropractor?**

○ Yes ○ No **Dr. Name:**

**Have you seen a neurologist?**

○ Yes ○ No **Dr. Name:**

**Have you had braces?**

○ Yes ○ No **Dr. Name:**

**Indicate which of the following you have had, or have at present. Tick "yes" or "no" for each item**

| | | |
|---|---|---|
| **Heart Concerns** | ☐ **Yes** | ☐ **No** |
| **Congenital Heart Disease** | ☐ **Yes** | ☐ **No** |
| **Heart Murmur** | ☐ **Yes** | ☐ **No** |
| **High Blood Pressure** | ☐ **Yes** | ☐ **No** |
| **Mitral Valve Prolapse** | ☐ **Yes** | ☐ **No** |
| **Artificial Heart Valve** | ☐ **Yes** | ☐ **No** |
| **Pacemaker** | ☐ **Yes** | ☐ **No** |
| **Stroke** | ☐ **Yes** | ☐ **No** |
| **Asthma** | ☐ **Yes** | ☐ **No** |
| **Liver Disease/Jaundice** | ☐ **Yes** | ☐ **No** |
| **Latex Sensitivity** | ☐ **Yes** | ☐ **No** |
| **Artificial Joints** | ☐ **Yes** | ☐ **No** |
| **Kidney Trouble** | ☐ **Yes** | ☐ **No** |
| **Radiation/Chemotherapy** | ☐ **Yes** | ☐ **No** |
| **Epilepsy/Seizures** | ☐ **Yes** | ☐ **No** |
| **Diabetes** | ☐ **Yes** | ☐ **No** |
| **Hepatitis** | ☐ **Yes** | ☐ **No** |
| **Sickle Cell Disease** | ☐ **Yes** | ☐ **No** |
| **Neurological Disorders** | ☐ **Yes** | ☐ **No** |
| **Psychiatric/Psychological Issues** | ☐ **Yes** | ☐ **No** |
| **Headaches** | ☐ **Yes** | ☐ **No** |
| **Jaw Pain** | ☐ **Yes** | ☐ **No** |
| **Jaw Popping** | ☐ **Yes** | ☐ **No** |
| **Limited Opening** | ☐ **Yes** | ☐ **No** |
| **Congested Ears** | ☐ **Yes** | ☐ **No** |
| **Dizziness** | ☐ **Yes** | ☐ **No** |
| **AIDS/HIV** | ☐ **Yes** | ☐ **No** |

| | | |
|---|---|---|
| Ringing Ears | ☐ Yes | ☐ No |
| Loose Teeth | ☐ Yes | ☐ No |
| Posture Problems | ☐ Yes | ☐ No |
| Clenching | ☐ Yes | ☐ No |
| Grinding | ☐ Yes | ☐ No |
| Facial Pain | ☐ Yes | ☐ No |
| Sensitive Teeth | ☐ Yes | ☐ No |
| Neck Ache | ☐ Yes | ☐ No |
| Bell's Palsy | ☐ Yes | ☐ No |
| Difficulty Swallowing | ☐ Yes | ☐ No |
| Difficulty Chewing | ☐ Yes | ☐ No |
| Trigeminal Neuralgia | ☐ Yes | ☐ No |
| Tingling in Arms/Fingers | ☐ Yes | ☐ No |
| Insomnia | ☐ Yes | ☐ No |
| Alcohol/Drug Abuse | ☐ Yes | ☐ No |
| Does floss shred when you use it? | ☐ Yes | ☐ No |
| Does food pack or catch between your teeth? | ☐ Yes | ☐ No |
| Do your gums bleed? | ☐ Yes | ☐ No |
| Does your breath concern you? | ☐ Yes | ☐ No |
| Would you like whiter teeth? | ☐ Yes | ☐ No |
| Do you smoke or chew tobacco? | ☐ Yes | ☐ No |

**Do you have or have you had any disease or problem not listed?**

**Women: Are you:**

| | | | | |
|---|---|---|---|---|
| **Pregnant?** | ☐ | **Yes** | ☐ | **No** |
| **Nursing?** | ☐ | **Yes** | ☐ | **No** |
| **Taking birth control pills?** | ☐ | **Yes** | ☐ | **No** |

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or mediations.

**Signature of Patient** **Date**